

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED JUN 7 1962

1003

5

NUMBER

VS 300  
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

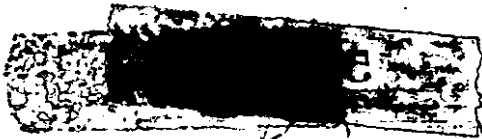
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS,		Length of stay in 1b		c. CITY OR TOWN ST LOUIS,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION OUR LADY OF PERPETUAL HELP NURSING HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 3619 GASCANADE AVE		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First CLEMENT		Middle HERWEG		Last		4. DATE OF DEATH MAY 26, 1962	
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/21/83		9. AGE (last birthday) 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ST LOUIS MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME JOSEPH HERWEG				13b. MOTHER'S MAIDEN NAME MARY LOEFFEL		14. NAME OF HUSBAND OR WIFE MINNIE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) NO				16. SOCIAL SECURITY NO.		17. INFORMANT R. D. SCOTT 24 BLAKEMORE PL.			
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS				PINE LAWN MISSOURI		INTERVAL BETWEEN ONSET AND DEATH Immediate			
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.				DUE TO (b) OBSTRUCTIVE EMPHYSEMA 527.1		2 yrs. app			
				DUE TO (c) CONGESTIVE HEART FAILURE		2 " "			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from 12-17-59, to 5-26-62 and last saw her him alive on 5-20-62 Death occurred at 2 a m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Dulcedo M.D.				(Degree or title)		22b. ADDRESS 3654 South Grand Blvd.		22c. DATE SIGNED 5-26-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/29/62		23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d. LOCATION (City, town, or county) ST LOUIS MISSOURI		(State)	
24. FUNERAL DIRECTOR STROOT - CARROLL 4600 NATURAL BRIDGE				ADDRESS		25. DATE RECD. BY LOCAL REG. MAY 28 1962		26. REGISTRAR'S SIGNATURE Dean Smith. M.D.	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

86



*In Case of  
3.6 54 32414  
for*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed M W Bueker

Licensed Embalmer No. 4865

P. O. Address St Louis MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.